



**Neil Cameron**  
**Assistant Coroner for South Yorkshire (East District)**

	<p><b>REGULATION 28 REPORT TO PREVENT FUTURE DEATHS</b></p> <p><b>THIS REPORT IS BEING SENT TO: Rosie Hanna</b> Head Of Safer Custody and Learning, Equalities, Rights and Decency Group, The Ministry Of Justice, Clive House, 70 Petty France, London SW1H 9EX</p>
1	<p><b>CORONER</b></p> <p>I am Neil Cameron, Assistant Coroner for South Yorkshire (East District)</p>
2	<p><b>CORONER'S LEGAL POWERS</b></p> <p>I make this report under paragraph 7, Schedule 5, of the Coroners and Justice Act 2009 and regulations 28 and 29 of the Coroners (Investigations) Regulations 2013. <a href="http://www.legislation.gov.uk/ukpga/2009/25/schedule/5/paragraph/7">http://www.legislation.gov.uk/ukpga/2009/25/schedule/5/paragraph/7</a> <a href="http://www.legislation.gov.uk/uksi/2013/1629/part/7/made">http://www.legislation.gov.uk/uksi/2013/1629/part/7/made</a></p>
3	<p><b>INVESTIGATION and INQUEST</b></p> <p>On 13/02/2014 I commenced an investigation into the death of Andrew Douglas Frere, 34 . The investigation concluded at the end of the inquest on 08 September 2015. The conclusion of the inquest was that he took his own life whilst the balance of his mind was disturbed.</p>
4	<p><b>CIRCUMSTANCES OF THE DEATH</b></p> <p>On 19<sup>th</sup> January 2014 Andrew Frere self harmed whilst a prisoner at HMP Moorland, Doncaster. He was placed on an ACCT, which remained open and which was subject to 11 reviews under the ACCT procedure until 10 February 2014, when he died as a result of suspending himself by a ligature formed from a bedsheet in his cell.</p> <p>He was initially placed on continuous observation and for this purpose was moved from the houseblock where he was located to a gated cell in the Induction Wing. He was diagnosed as suffering from depression with some psychotic features, and appeared in particular to have concerns about returning to reside on the houseblock and about which would happen following his forthcoming release from prison. As regards the former concern, although he clearly felt more comfortable on the Induction Wing, it was recognised that long-term residence on that wing was not practicable, and that he would have to be reintegrated onto the houseblock at some point. It was also recognised that it was undesirable for him to remain under constant observation for any longer than was necessary.</p> <p>Andrew Frere appears to have made good progress under the ACCT, but the improvement was not without setbacks during which he felt low in mood and expressed suicidal ideation. Those were appropriately recorded in the ACCT ongoing record.</p>

At the ninth review, held on 31 January 2014, the level of observation was reduced to one per hour. At the tenth review, on 4 February 2014, it was decided to move him back to his cell in the houseblock. At the eleventh review, on 7 February 2014, this level of observation was further reduced to 6 per 24 hours. He hanged himself in his cell during a short period when prisoners were locked up for lunch, between 12.30 pm and 1.30 pm.

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**CORONER'S CONCERNS**

During the course of the inquest the evidence revealed matters giving rise to concern. In my opinion there is a risk that future deaths will occur unless action is taken. In the circumstances it is my statutory duty to report to you.

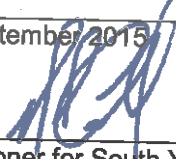
The **MATTERS OF CONCERN** are as follows. –

(1) Prison Service Instruction 64/2011 requires that prisoners under continuous observation should be seen by a doctor very 24 hours. The evidence given at the inquest indicated that this was not practicable, and the rule was widely recognised as not being so practicable.

My concern is less or to the apparent impracticability of the PSI, but more that, this impracticability having been recognised, the rule appears to have been ignored, rather than any attempt having been made at least to comply as closely as possible. Since Andrew Frere's death this is now done at HMP Moorland by having nursing staff see the prisoner when a doctor is not available, but the problem with the impracticability of the PSI appears to be national, rather than a local one, and ought to be the subject of some sort of guidance at national level.

(2) The PSI does not appear to include any specific instruction that the case manager, or others attending ACCT review, should ensure that they read the ongoing observations, at least as far back as the previous review, in order to ensure that they are aware of recent events when they carry out such a review.

My concern is that potentially important information, which might affect decisions taken at the review, may be missed if the recent observations are not read.

6	<p><b>ACTION SHOULD BE TAKEN</b></p> <p>In my opinion action should be taken to prevent future deaths and I believe you have the power to take such action.</p>
7	<p><b>YOUR RESPONSE</b></p> <p>You are under a duty to respond to this report within 56 days of the date of this report, namely by <b>03 November 2015</b>. I, the coroner, may extend the period.</p> <p>Your response must contain details of action taken or proposed to be taken, setting out the timetable for action. Otherwise you must explain why no action is proposed.</p>
8	<p><b>COPIES and PUBLICATION</b></p> <p>I have sent a copy of my report to the Chief Coroner and to the following Interested Persons  ██████████ c/o Howells Solicitors, 15-17 Bridge Street, Sheffield, S3 8NL, Ref: CK.247806</p> <p>Nottinghamshire Healthcare NHS Trust, c/o Mills and Reeve Solicitors, Botanic House, 100 Hills Road, Cambridge, CB2 1PH, Ref:BDHA/4005783-1304</p> <p>I am also under a duty to send the Chief Coroner a copy of your response.</p> <p>The Chief Coroner may publish either or both in a complete or redacted or summary form. He may send a copy of this report to any person who he believes may find it useful or of interest. You may make representations to me, the coroner, at the time of your response, about the release or the publication of your response by the Chief Coroner.</p>
9	<p>Dated 08 September 2015</p> <p>Signature   Assistant Coroner for South Yorkshire (East District)</p>